OBJECTIVES: Patients undergoing surgery for hip fracture are in the highest category of risk for postoperative venous thromboembolism, but data on thromboprophylaxis in these patients were scarce. Fondaparinux, a new synthetic selective factor Xa inhibitor proved to be more effective than enoxaparin in preventing venous thromboembolism in these patients and was equally safe. We evaluated its cost-effectiveness relative to enoxaparin over a period of five years post-surgery. **METHODS:** We modelled the impact of fondaparinux based on 7-day prophylaxis on patient outcomes and costs to the UK National Health Service (NHS). Outcomes are thromboembolic events (symptomatic deep vein thrombosis, pulmonary embolism), and long term complications (recurrences, post thrombotice syndrome), and death. Probabilities for efficacy and safety outcomes were derived from randomised clinical trials comparing enoxaparin with fondaparinux, and from a review of the literature. Resource consequences were estimated from a survey of UK hospitals and a panel of clinical experts. Costs were estimated using mean national costs to the NHS. **RESULTS:** In a hypothetical cohort of 1000 patients, fondaparinux is estimated to prevent 23 additional thromboembolic events (clinical VTE) and 6 deaths compared to enoxaparin, with savings fully compensating added costs of prophylaxis by day 30 (break-even point). Total savings for the cohort would be £29,000 at 5 years. These findings are robust to wide variations in key assumptions in the model. **CONCLUSIONS:** Compared with enoxaparin, fondaparinux is a cost-effective and dominant strategy in prophylaxis against venous thromboembolism following hip fracture surgery. Benefits of using fondaparinux begin early following surgery, with savings increasing over time.

PCV23

ECONOMIC IMPACT OF CLOPIDOGREL IN PATIENTS WITH ACUTE CORONARY SYNDROMES WITHOUT ST-SEGMENT ELEVATION (ACS) UNDERGOING PERCUTANEOUS CORONARY INTERVENTIONS (PCI): A EUROPEAN OVERVIEW

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OBJECTIVE: The PCI-CURE study demonstrated that clopidogrel compared to placebo, both groups receiving standard therapy including ASA reduces the risk of major cardiovascular events in patients with ACS undergoing PCI. The purpose of this analysis was to evaluate the cost per event avoided in Austria, Belgium, Italy, Spain, and Switzerland. **METHODS:** The composite outcome used for the cost-effectiveness analysis was the difference in occurrences of all cardiovascular deaths, myocardial infarctions, and strokes. Costs of hospitalization, procedures, comedications and study drug were calculated based on resource utilization reported for all patients undergoing PCI in the CURE study. Hospitalization costs were evaluated through a Diagnosis Related Group approach in all countries. Unit costs were developed in each country and applied to all patients of the CURE study. Cost-effectiveness was expressed as the cost per event avoided, in analogy with previously published evaluations in this area. The time horizon was that of the clinical trial (12 months). **RESULTS:** The occurrence of the composite outcome was significantly lower in the clopidogrel arm compared to placebo (11.65% versus 15.17%). For every 1000 patients treated with clopidogrel 35 additional atherothrombotic events were avoided. The total cost of managing a patient with ACS undergoing PCI ranged from €5,728 to €13,604 in the placebo arm depending on the country. This cost was increased by +1.2% to +4.9% in the clopidogrel arm. The cost of clopidogrel was partly offset by savings due to less severe main diagnosis during hospitalizations. The incremental cost per patient ranged from €166 to €390. This resulted in a cost per cardiovascular event avoided ranging from €4,732 to €11,065, which is better compared to other interventions in this area. **CONCLUSION:** Clopidogrel in patients with ACS undergoing a PCI is cost-effective and results are very consistent across European countries.

PCV24

THE MAHLER STUDY: DIFFERENCES IN RESOURCE USE FOR THE MANAGEMENT OF CHRONIC HEART FAILURE ACROSS 6 EUROPEAN COUNTRIES

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OBJECTIVES: To identify and to explain the possible differences in resource use for the treatment of chronic heart failure (CHF) in France (F), Germany (G), Italy (I), the Netherlands (NL), Spain (S), and the United Kingdom (UK). **METHODS:** MAHLER was a multi-centric observational (non-interventional) study on the medical management, the health care resource use and the cost of CHF. A total of 1421 NYHA (New York Heart Association) class II to IV patients were included and were prospectively followed over 6 months. The frequencies of patients using a specific resource and the mean number of uses were computed for each country. Predictors of